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Certificate of Need: Protecting Providers, Not Controlling Costs

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Certificate of Need (CON) programs originated in the early 1970s as a means to reduce health care costs by preventing the duplication of services. Rigorous studies of the success of CON programs in controlling costs are virtually unanimous in concluding that the programs failed. Yet today, 27 states continue to have CON laws regulating hospitals and 37 have such laws limiting nursing homes. Moreover, there is renewed interest in some quarters to strengthen existing laws and reintroduce the programs in states that have repealed them.

The new and continued interest stems from efforts by providers to be protected from the competition posed by new entrants and by old competitors moving to new locations. Indeed, the Federal Trade Commission and the U.S. Department of Justice, in a report on the health care industry released in the summer of 2004, recommended that:

> States with Certificate of Need programs should reconsider whether these programs best serve their citizens' health care needs. The Agencies believe that, on balance, CON programs are not successful in containing health care costs, and that they pose serious anticompetitive risks that usually outweigh their purported economic benefits. Market incumbents can too easily use CON procedures to forestall competitors from entering an incumbent's market.[77]

This chapter provides a review of the existing research on the effects of certificate of need on costs, prices, and the diffusion of services. It describes the nature of health care markets that have emerged over the last 20 years and discusses how the development of price competition among health care providers has made CON a vehicle to keep prices up rather than costs down.

CERTIFICATE OF NEED IN MARYLAND

The Maryland health system, by state law, must receive a "Certificate of Need" from the Maryland Health Care Commission (MHCC) to build a new facility. It also needs a CON to offer various new or expanded health services. Indeed, the American Health Planning Association reports that the MHCC regulates 16 areas of health services in Maryland.

According to a 2001 report the MHCC produced for the Maryland General Assembly, the CON process is intended to ensure no "over-building" or "over-utilization" of health-care services, and to "limit the number of programs providing some highly specialized services."[78] In other words, the MHCC strives to hold down the number, types, and locations of various health-care facilities and services throughout Maryland, for fear that free enterprise and consumer demand would lead to too much health care provided at too low a price.

The MHCC accomplishes this by using the CON process to award local franchises to various health-care providers, thus limiting competition over price, quality, and convenience.

The MHCC claims that CON is necessary for proper health-care "planning" and to ensure that health-care facilities remain economically viable. It even claims CON keeps medical costs low. This view is inconsistent with the findings of academic analysis. Careful studies conducted over the last 20 plus years conclude that CON has not kept med-

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77. Available at: *http://www.mhcc.state.md.us/certificateofneed/_certificateofneed.htm*.
78. Good historical summaries may be found in Bruce Steinwald and Frank A. Sloan, "Regulatory Approaches to Hospital Cost Containment," in Mancur Olsen, ed., *A New Approach to the Economics of Health Care*. (Washington: American Enterprise Institute, 1981): 274-308; and James B. Simpson, "State Certificate-of-Need Programs: The Current Status," *American Journal of Public Health* 75(10): 1225-1229, October 1985.

ical costs low. Instead, CON in Maryland, like elsewhere, has thwarted competition and protected existing providers from the rigors of the marketplace.

BACKGROUND

CON is a process of state approval required of hospitals, nursing homes, and some other entities prior to the construction or renovation of a facility or the addition of major new programs or equipment. New York was the first state to develop a CON process in 1964. New beds or major capital purchases could be licensed only if they were approved by the state health-planning agency. By 1975, some 26 states had enacted CON legislation.

The federal government enacted health-planning legislation in 1976 requiring that hospitals and nursing homes have prior approval for new facilities and major equipment if the care rendered using the facilities and equipment was to be eligible for reimbursement under Medicare and Medicaid. If a state did not adopt a CON program to consider such requests for expansions, a federal process would be used. All states except Louisiana enacted health-planning laws.[79]

In the early 1980s, the federal government largely eliminated funding for health planning, and in 1987, the federal health planning statute was repealed, in part because it was ineffective at controlling costs. Between 1983 and 1996, 15 states dropped their CON laws for hospitals and five repealed them for nursing homes.[80] However, the majority of states continue to have CON regulations in place and others have restored elements of earlier programs.

The provisions of current regulations vary significantly by state. The American Health Planning Association (AHPA) reports that in 2004, 36 states had at least one category of service covered by a CON program. All 36 covered nursing homes, and 26 states had programs applicable to hospitals. The AHPA tracks over 30 categories of services that are sometimes subject to CON review. These include such services as ambulatory

79. Michael A. Morrisey, "State Health Care Reform: Protecting the Provider," in Roger Feldman, ed., *American Health Care: Government, Market Processes and the Public Interest*. (New Brunswick: Transaction Publishers for the Independent Institute, 2000): 229-266.
80. American Health Planning Association. National CON Perspective, 2004. Accessed at: *http://www.ahpanet.org/Images/NASHPpiper.pdf*.

surgery centers (25 states), substance abuse services (21 states), and hospice care (3 states). The states adopt cost thresholds for the review of new or renovated facilities and services. It is not uncommon for the capital cost threshold to be $2 million and medical equipment cost threshold to be $1.5 million.[81]

EMPIRICAL EVIDENCE ON CERTIFICATE OF NEED PROGRAMS

Most rigorous empirical studies have found that certificate of need has virtually no cost containment effects. However, they do show higher profits, some protection of existing hospital management, and mixed results with respect to the diffusion of new technology.

Consider cost containment first. In a pair of early studies, Frank Sloan used state data from 1963–1980 to examine the effects of the enactment of CON on the level of hospital costs and the change in costs per day and per admission.[82] He looked for anticipatory effects of hospitals trying to "beat" CON implementation, as well as the effects of CON programs in the developmental and mature periods. Sloan found that CON had no statistically meaningful effect on costs or changes in costs. These findings have been borne out by other early state-level analyses.[83] Morrisey, Sloan, and Mitchell used metropolitan-area data from 1967

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81. Frank A Sloan, "Regulation and the Rising Cost of Hospital Care." *Review of Economics and Statistics* (November 1981): 63(4): 479-487; and Frank A. Sloan, "Rate Regulation as a Strategy for Hospital Cost Control: Evidence from the Last Decade," *Milbank Memorial Fund Quarterly* (1983): 61(2): 195-232.
82. David Salkever and Thomas Bice, *The Impact of Certificate of Need Controls: Impact on Investment, Costs and Use* (Washington: American Enterprise Institute, 1979); Glenn A. Melnick, et al., "Effects of Rate Regulation on Selected Components of Hospital Expenses," *Inquiry* (Fall 1981): 18:240-246; Paul L. Joskow, *Controlling Hospital Costs: The Role of Government Regulation* (Cambridge: MIT Press, 1981); Glen I. Misek and Roger A. Reynolds, "Effects of Regulation on the Hospital Industry," *Quarterly Review of Economics and Business* (Autumn 1982): 22(3): 66-80; and John L. Ashby, "The Impact of Hospital Regulatory Programs on Per Capital Costs, Utilization, and Capital Investment," *Inquiry* (Spring 1984): 21:45-59.
83. Michael A. Morrisey, Frank A. Sloan, and Samuel Mitchell, "State Rate Setting: An Analysis of Some Unresolved Issues," (July 1983): *Health Affairs* 2(2): 36-47.

through 1981 and found no effect of CON on hospital costs.[84] Sloan and Steinwald used 1970–1975 hospital-level data and found no statistically meaningful effect of CON on hospital costs.[85] Coelen and Sullivan used hospital data from 1969–1978 and also found no meaningful effects of CON on hospital costs.[86]

More recent investigations have examined the potential effects of CON over longer periods. They have evaluated the effects of CON repeal and considered the interaction of CON with other regulatory programs. These studies suggest that rather than controlling costs, CON programs have tended to increase costs. Antel, Ohsfeldt, and Becker used 1968-1990 state data on hospital costs per day, per admission, and per capita. They allowed for interaction effects between CON programs and other state and federal regulatory programs, thereby allaying the concern of some proponents that one must look how regulatory programs fit together in the state. They found that CON had no statistically significant effects in any of the empirical specifications.[87] Indeed, their estimates imply that CON raised hospital costs. Lanning, Morrisey, and Ohsfeldt worried that CON programs may have been implemented and maintained in states that had higher costs to begin with. Even after taking this into account, they found that hospitals in states with CON had costs 20.6 percent higher than hospitals in states without CON.[88]

The most recent study of CON only confirms this earlier research. Conover and Sloan examined state health care costs per capita from 1980–1993. They found that CON programs had no effect on health care spending per capita and the repeal of CON laws similarly had no

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84. Frank A. Sloan and Bruce Steinwald, "Effects of Regulation on Hospital Costs and Input Use," *Journal of Law and Economics* (April 1980): 23:81-109.
85. Craig Coelen and Danile Sullivan, "An Analysis of the Effects of Prospective Reimbursement Programs on Hospital Expenditures," *Health Care Financing Review* (1980): 2:1-40.
86. John J. Antel, Robert L. Ohsfledt, and Edmund R. Becker, "State Regulation and Hospital Costs," *Review of Economics and Statistics* (August 1995): 77:416-422.
87. Joyce Lanning, Michael A. Morrisey, and Robert L. Ohsfeldt, "Endogenous Hospital Regulation and Its Effects on Hospital and Non-hospital Expenditures," *Journal of Regulatory Economics* (July 1991): 2:137-154.
88. Christopher Conover and Frank A. Sloan, "Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?" *Journal of Health Politics, Policy and Law* (June 1998): 23(3): 455-481.

statistically significant effect.[89] Thus, nearly 20 years of studies have concluded that hospital CON has not reduced health care costs.

State Medicaid commissioners and other advocates of CON in long-term care markets have argued that the presence of CON limits the number of nursing home beds and thereby limits the expenditures of strapped Medicaid programs. However, this speculation had not been rigorously tested until recently. Grabowski, Ohsfeldt, and Morrisey examined the effect of the repeal of state CON and construction moratoria on Medicaid expenditures for nursing home and long-term care services. Using state data from 1981–1998, they found that eliminating nursing home CON and construction moratoria had no effect on Medicaid expenditures.[90]

While CON did not control costs, there is some evidence that it has kept prices up and limited organizational threats to hospitals. Conover and Sloan investigated the effects of CON and CON repeal on hospital profits. They concluded that the presence of CON resulted in hospital profits that were 15 to 25 percent higher, but that the repeal of CON had no effect on profitability.[91] The finding of higher hospital profits under CON is consistent with early work by Noether who analyzed data from the late 1970s and concluded that while CON had no effect on hospital costs, it raised hospital prices and resulted in higher hospital profits.[92]

There is some suggestion that CON programs protect hospitals from organizational changes. In two related studies, Alexander and Morrisey examined the growth of multihospital systems and contract management of hospitals during the early 1980s. They found that the longer the state's CON program was in effect, the less likely the hospital was to join a multihospital system and be contract-managed. They concluded that the certificate of need 'franchise' appeared to convey some market

89. David C. Grabowski, Robert L. Ohsfeldt, and Michael A. Morrisey, "The Effect of CON Repeal on Medicaid Nursing Home and Long Term Care Expenditures," *Inquiry* (Summer 2003): 40:146-157.
90. Conover and Sloan, 1998.
91. Monica Noether, "Competition Among Hospitals," *Journal of Health Economics* (September 1988): 7(3):259-284.
92. Jeffrey Alexander and Michael A. Morrisey, "Hospital Selection into Multihospital Systems." *Medical Care* (February 1988): 26(2):159-176; and Jeffrey Alexander and Michael A. Morrisey, "A Resource-Dependence Model of Hospital Contract Management," *Health Services Research* (June 1989): 24(2):259-284.

power that increased the value of the hospital to its current owners and protected weaker hospitals from pressures for new management.[93]

Finally, a number of studies tried to identify the effects of CON on the diffusion of various forms of technology. Conover and Sloan recently reviewed these and provided their own analysis of several services. Their overall conclusion was that in nearly 70 separate tests of the relationship between CON and the rate or extent of diffusion contained in several studies, only about one-third found that CON retarded diffusion; a few found that CON accelerated diffusion, but the majority found no effect in either direction. Of particular interest, Conover and Sloan were the only ones to examine the effects on the diffusion of ambulatory surgery units; they found that CON had no effect on their diffusion.[94]

COMPETITION AND HEALTH CARE MARKETS

One could make a cost control case for CON in the health care world of the 1970s. Insurers paid hospitals based on cost. So, everything the physician and the hospital did for the patient generated costs and these costs translated, almost dollar-for-dollar, into payments. Since price played a minimal role in decision-making, hospitals logically competed for patients based on things that did matter: services, amenities, and quality. The result was a "medical arms race" in which new services attracted patients, some from other facilities. Services were underutilized and the full costs were passed on to insurers and their subscribers.

CON tried to restrict the services to reduce "duplication" and thereby limit costs. However, the problem wasn't the services; the problem was the payment system. Providers never saw the consequences of building capacity beyond the demand for services. In the hotel market, for example, if new and existing hotels in a city build too many new hotel rooms, they can't rent the rooms at the prices they had hoped. Therefore, to attract guests, they cut prices. Prices would be pushed down to marginal costs and the least efficient or the least desirable hotels would ultimately close. In contrast, in the hospital industry of the 1970s, the costs of the new rooms were added to the hospital's total expenditures and then divided by hospital admissions or patient days. This higher average cost

93. Conover and Sloan, 1998.

94. Jack Zwanziger and Glenn A. Melnick, "The Effects of Hospital Competition and the Medicare PPS Program on Hospital Cost Behavior in California," *Journal of Health Economics* (1988): 7(4):301-320.

was passed on to insurers and to government programs in the form of higher cost-based reimbursement formulas.

HEALTH CARE MARKETS TODAY

As we saw in the summary of the research presented earlier, CON did not solve the cost problem of the 1970s. This should be no surprise. Hospitals were competing for patients and prices were largely irrelevant. If CON limited some methods of competition, such as new hospitals and major new services, it did not, and could not, control them all, and costs were always passed on and paid by insurers.

The health care market saw fundamental change in the late 1980s and 1990s. The results changed the way hospitals and other providers made service decisions and made CON not only ineffective, but also counter-productive.

Beginning largely in California but spreading across most of the country, managed care plans began to "selectively contract". This means that rather than give a contract to any and every hospital, they only gave them to some, based upon services, amenities, quality, and price. This approach changed the economic dynamics. Now hospitals had to consider not only the ability of new services to attract physicians and their patients, but also whether the new services would generate enough revenue to cover the extra costs. Selective contracting meant that ordinary economics would apply in the hospital market.

In the early California experience after the introduction of selective contracting, markets with many hospitals (i.e., competitive markets) went from being high cost-growth areas to being low cost-growth areas.[95] In markets with more hospitals, managed care plans negotiated lower prices with hospitals; in markets with more idle capacity, given the number of hospitals, managed care plans got still lower prices. Even in hospitals with high occupancy, managed care plans could successfully negotiate lower hospital prices when other hospitals in the market had

95. Glenn A. Melnick, Jack Zwanziger, Anil Bamezai, and Robert Pattison, "The Effects of Market Structure and Bargaining Position on Hospital Prices," *Journal of Health Economics* (1992): 11(3):217-233.

low occupancy.[96] There is strong evidence that these effects have been replicated outside of California and throughout the 1990s.[97]

Research using 1995 data from Massachusetts suggests the magnitude of the price differentials generated by selective contracting. The study analyzed claims data on eight medical conditions from the one fee for service (FFS) and 10 HMO plans offered to Massachusetts state employees. The study found that 47 percent of the cost differences between the FFS and the HMOs were attributable to differences in the incidence of disease, but 45 percent resulted in differences in the price for the same services. For example, the FFS plan paid, on average, $64,109 for a CABG (coronary artery bypass graft), while the HMOs paid $51,885. For Cesarean section delivery the FFS plan paid $14,964; the HMOs paid $10,103. The average difference in prices across all eight procedures was nearly $6,500.[98] Today only about five percent of workers with employer-sponsored health insurance are in fee-for-service plans. Ninety-five percent are in some form of managed care.[99] Selective contracting is the order of the day.

CERTIFICATE OF NEED IN A COMPETITIVE ENVIRONMENT

CON impedes the functioning of hospital markets in the presence of selective contracting. With selective contracting, "duplication" is a good thing. It means that hospitals have the potential to offer similar services and to get the contract if the price, services, and quality are better than those offered by neighboring hospitals. Unlike the cost-based payment era, in the era of selective contracting if hospitals provide more services than is demanded, the hospitals incur the costs of the errant decisions, not the consumers.

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96. Michael A. Morrisey, "Competition in Hospital and Health Insurance Markets: A Review and Research Agenda." *Health Services Research* (April 2001): 36(1, part 2):191-221.
97. Daniel Altman, David Cutler, and Richard Zeckhauser, "Enrollee Mix, Treatment Intensity, and Cost in Competing Indemnity and HMO Plans." *Journal of Health Economics* (2003): 22(1):23-45.
98. Jon Gabel, et al., "Health Benefits in 2004: Double Digit Premium Increases Take Their Toll on Coverage," *Health Affairs* (Sept/Oct 2004): 23(5):117-126.
99. Morrisey, 2000, 250-251.

In today's price competitive health care environment CON has become a mechanism to delay or prevent the introduction of services offered by another seller. Press reports were common in the early 1990s reporting local instances where existing providers used the CON. Morrisey reported several of these:[100]

- In Lebanon, Tennessee, a hospital sought to rebuild its facility five miles away from its existing, flood-prone site. The other hospital in the community, located two miles from the new site, opposed the CON authorization on the grounds that the community was already overbedded. After more than three years of hearings and appeals, the legislature passed a law allowing the renovation.
- In Olympia, Washington, a national chain sought to build a 44-bed rehabilitation hospital. One month later a local hospital submitted a similar CON request. Three other hospitals formally opposed the applications because they already provided an adequate supply of rehabilitation beds. A representative of the state health department observed, "Things have gotten competitive for hospitals. It's not unusual for a hospital to oppose another hospital's CON application."

In July 2004 the joint FTC-DOJ report on health care markets reported on testimony the Agencies received on the anticompetitive effects of CON:[101]

- "He stated that his practice's application to a state for a certificate of need to introduce improved cancer radiation technology faced opposition in June 2002 from all of the state's operators of existing radiation therapy equipment. One year later, at the time of his testimony in the Hearings, he noted that the state still had not approved the CON application. By contrast, in a bordering state without a CON program, his practice was able to introduce new cancer-fighting technologies rapidly."
- "Another panelist stated that incumbent home health service providers in her state have, for 23 years, successfully opposed the CON application of her nursing service, thereby barring its entry and

100. Federal Trade Commission, Department of Justice, 2004, Chapter 8: 4.
101. "Few Pros to This CON: Certificate of Need Laws, once Useful, Now Prevent More Hospitals from Providing Open-Heart Surgery," *Atlanta Journal Constitution* (December 9, 2004). Accessed at: *http://www.ajc.com/opinion/content/opinion/1204/09con.html*.

keep[ing] the oligopoly in place. The incumbents, she stated, charge more for comparable services than her service would."

Such stories are commonplace. One may simply undertake a "Google News" search on "CON" to find current examples of CON used to limit competition. A December 2004 search revealed:

- In Atlanta, Georgia, Kennestone Hospital began providing open-heart surgery in the booming north suburbs this month. It had wanted to provide these services for over a decade. It broke the first regulatory hurdle five years ago when it teamed up with Emory University physicians. Even after the state gave it a CON approval, it took nearly three years in court to fend off challenges from some of its remaining competitors.[102]

- In Brevard County, Florida, Health First has obtained a hearing before an administrative law judge to contest its denial by the Agency for Healthcare Administration of a CON to build a 100-bed hospital in Viera, Florida. The construction is opposed by Wuesthoff Hospital. Ironically, Wuesthoff and Health First were engaged in a protracted effort between 1997 and 2000 to prevent Wuesthoff from building its own hospital in Melbourne, Florida, just up the road from the proposed new Health First hospital.[103]

These examples suggest that rather than controlling costs, CON is impeding competition. As the FTC-DOJ concluded in their report:

- The Agencies believe that CON programs are generally not successful in containing health care costs and that they can pose anticompetitive risks. As noted above, CON programs risk entrenching oligopolists and eroding consumer welfare. The air of controlling costs is laudable, but there appear to be other, more effective means of achieving this goal that do not pose anticompetitive risks. A similar analysis applies to the use of CON programs to enhance health care quality and access. For these reasons, the Agencies urge states with CON programs to reconsider whether they are best serving their citizens' health care needs by allowing these programs to continue.[104]

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102. " Viera Proposal Spurs Old Rivalry," *Business Florida Today* (December 6, 2004). Accessed at: *http://www.floridatoday.com/!NEWSROOM/moneystoryB1207HOSPITALS.htm*.
103. Federal Trade Commission, Department of Justice, 2004, Chapter 8: 6.

In today's competitive health care environment, CON is merely a mechanism to protect existing providers from the challenge posed by new entrants who threaten established providers.

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104. "Improving Health Care: A Dose of Competition," Federal Trade Commission and the Department of Justice (Washington, DC: FTC-DOJ, July 2004): 22; available at: *http://www.usdoj.gov/atr/public/health_care/204694.htm*.